

# Public Health Watch



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METROPOLITAN HEALTH DEPARTMENT OF NASHVILLE AND DAVIDSON COUNTY, TENNESSEE

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## Welcome to this special edition of *Public Health Watch* devoted to the Division of Maternal Child Health!

**“Leave no child behind,”** a phrase coined by Marian Wright Edelman of the Children’s Defense Fund (CDF) was adopted earlier this year by the current administration. It has become one of President Bush’s favorite mottos. However, the struggle to lift up, nurture, and protect the well being of every child has continued to be a battle, and it is far from over.

In their *State of Children in America’s Union*, the Children’s Defense Fund states, “The state of millions of children in the richest most powerful democratic nation in the world is morally shameful, economically costly, and politically hypocritical.” According to their statistics, a child is born into poverty every 43 seconds, and 1 in 5 children is poor during the first 3 years of their lives. The majority of 4<sup>th</sup> graders can’t read or do math at a proficient level; nearly 12 million children are poor; and millions are hungry, at risk of hunger, living in worst case housing, or are homeless.

The numbers in Nashville are similar to the national trend. Our infant mortality rates for black infants increased nearly 83% in 2000 from 1996 rates. Similarly, the number of deaths of children ages 10 - 19 increased over 76% in 2000 from 1990 statistics. Although we have improved in the areas of low birth weight babies, the racial ethnic disparities that over shadow these improvements are disheartening. A black infant is over 40 times more likely to die as a result of perinatal conditions.<sup>1</sup> In many ways, we as a nation, state, and community talk the talk, but turn our backs when

it is time to walk the walk. As a result, we have continued to leave our children behind.

Marian Wright Edelman commented that, “With the \$1.3 billion dollars from the current federal tax cut plan, we could, “cover every child with health insurance, provide Head Start and quality child care for all in need.” We could rebuild our dilapidated schools, and come closer to assuring that no child goes to bed hungry or homeless. As a whole, we have not made this commitment to our children; instead, we remain paralyzed in the act of picking up the pieces that make up the lives of our most vulnerable citizens.

In this special Maternal Child Health edition of *Public Health Watch*, we would like to take this opportunity to showcase some of the incredible programs and projects that the dedicated staff are involved in, all centered around the well-being of the children we at the Metro Public Health Department refuse to leave behind!

The task to care for our most at risk children is a daunting one, however, with the spirit of dedication, collaboration, and determination and with each program assuring a complimentary piece of the puzzle, we will succeed in reaching our ultimate goal: *Healthy children living free from disease, injury, and disability!*

Kimberlee Wyche-Etheridge, MD, MPH,  
Director Maternal Child Health

Reference:

<sup>1</sup> Tennessee Commission on Children and Youth. *Kids Count 2001. The State of the Child in Tennessee*. Tennessee Kids Count. Nashville, TN: 2001.

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# Central Referral System

Delphine Gentry, RN, Intake Coordinator

In 1996, the Child Death Review team recommended that infant services be better coordinated. The Metro Public Health Department, along with two community based groups, the Nashville Agencies Serving Young Children and Healthy Nashville 2000+ Maternal and Infant Health Team agreed that a better system was needed to coordinate referrals for case management services. The Central Referral System (CRS) began services on January 1, 1997. The system was designed to facilitate appropriate intervention services for pregnant women and young children (0 – 7 years). The office is presently located at the Metro Public Health Department – Vine Hill. *The phone number is 615-880-2187, and the fax number is 615-880-2190.* To refer pregnant women and children who need services, physicians, hospitals, social agencies, and lay citizens may call or fax the CRS office. After completing the referral intake form, the information will be reviewed and coordinated with the most appropriate agency or provider. A follow-up will be done to ensure that the appropriate services have been provided. The CRS is like a hub of a wheel, it allows referrals to come into one central location, links families to the appropriate providers, ensures coordination/follow-up of services, avoids duplication of services, and simplifies the referral process which allows more clients to be served. Approximately 1,000 referrals are processed per year.

The CRS office also facilitates requests from the Tennessee State Laboratory to assist with the follow-up of repeat newborn screenings and elevated lead levels of infants/young children.

## **Metabolic Newborn Screening (NBS)**

NBS is a blood test for five rare disorders of the infant's blood chemistry. This test is required by law. The blood test should be done within 24 – 48 hours of birth. Newborns with one of these disorders usually appear normal at birth, however, without treatment, the newborn becomes high risk for serious illness, mental retardation, and death. The five disorders are:

1. **PKU (Phenylketonuria):** Infants lack the enzyme needed to breakdown part of a protein in food (phenylalanine). The disorder, left untreated, causes mental retardation but can easily be treated with a special diet low in phenylalanine.<sup>1</sup>
2. **Galactosemia:** Infants lack the enzyme needed to breakdown sugar (galactose). The untreated infant becomes very ill and is at high risk for cataracts, mental retardation, infections, and death. The disorder can be treated with a special galactose-free diet.<sup>1</sup>
3. **Hypothyroidism:** The thyroid gland fails to produce enough thyroid hormone for the infant. The disorder interferes with normal growth and causes mental retardation. The disorder can be treated with medication.<sup>1</sup>



Delphine Gentry, RN, Intake Coordinator

4. **CAH (congenital adrenal hyperplasia):** Infants lack the enzyme needed for hormone production. Abnormal hormone levels can cause the infant to become very ill and can lead to death if not treated with medication.<sup>1</sup>
5. **Hemoglobinopathies (sickle cell, Hgb C, thalassemia disease or trait):** Some of the infant's red blood cells change from a normal round shape to a sickle shape. The sickle shaped red blood cells can clog blood vessels and interfere with the delivery of oxygen to the body. Infants are at risk for "sudden death" from infections caused by complications of this disorder. An average of 1 of 12 African Americans has sickle cell trait. The disease can be managed with proper medical treatment. There is no cure for these disorders,

*continued on page three*

however, the effects can be lessened and/or prevented with early detection and proper treatment.<sup>2</sup>

The CRS follow up protocol for repeat NBS begins with a phone call to the mother/guardian. If unable to reach by phone, a letter is sent to the client informing them of the need for a repeat NBS test. If there is no response from the client within a reasonable amount of time, then a home visit is made. Patient education materials and teaching are provided for the client as well as referral for genetic counseling if needed. The date and results of the second NBS test are documented.

### **Lead Poisoning**

Lead poisoning is a condition caused by inhaling or swallowing lead. Lead poisoning can cause devastating effects on health such as brain and kidney damage, coma, and death. Slightly elevated blood lead levels can cause learning disabilities and hyperactivity. No level of lead in the blood is beneficial. Children from birth to 6 years of age are at an increased risk for lead poisoning because they absorb a much higher amount of lead and their growing bodies are more susceptible to the damaging effects of lead. Pregnant women, individuals living in poverty and/or living in housing built before 1978 are also at high risk. Houses built before 1978 are likely to contain lead-based paint. Paint chips and dust from deteriorating lead-based paint are common sources of lead. Other sources include water from lead pipes, contaminated soil, food/drinks stored in lead-glazed pottery/dishes, and lead crystal. Lead might also be found in imported vinyl mini-blinds, some folk medicines, ethnic cosmetics, ammunition, and some hobby materials. In severe cases, medical treatment and/or hospitalization may be required. A capillary blood lead level test result of 10 ug/dl or above will require a venous blood confirmation test.<sup>3</sup>

The CRS follow-up protocol for elevated blood lead levels begins with a phone call to the mother/guardian. If unable to reach by phone, then a letter is sent to the client informing them of the need for repeat testing. Depending on the time frame and blood lead level, a home visit will be made instead of/or in addition to a letter. An assessment of the child and his/her surroundings will be done during the home visit. Educational materials and patient teaching are provided. Arrangements are made with the environmental specialist to schedule an environmental inspection of the client's home or suspected source of lead poisoning. Follow up is provided following recommendations from the Centers for Disease Control and Prevention.

### **References:**

- <sup>1</sup> Tennessee Department of Health. "Your Baby and Metabolic Newborn Screening." Newborn Screening Program. September 2000.
- <sup>2</sup> Whitten C. "Fact Sheet for Parents of Newborns Who Have Sickle Cell Trait." Wayne State University School of Medicine. Sickle Cell Disease Association of America.
- <sup>3</sup> Tennessee Department of Health. "Lead Poisoning Fact Sheet." Available at: [www2.state.tn.us/health/FactSheets/lead\\_poisoning.htm](http://www2.state.tn.us/health/FactSheets/lead_poisoning.htm). Accessed on September 24, 2002.

The CRS is like a hub of a wheel, it allows referrals to come into a central location, links families to the appropriate providers, ensures coordination/follow-up services, avoids duplication of services, and simplifies the referral process which allows more clients to be served.

# How We Grow with Help from HUG

Ruth Ann Barr, BSN

**H**ave you had a hug recently? Currently, more than 125 families throughout Davidson County have, thanks to the Metropolitan Public Health Department's "Help Us Grow" (HUG) program. The HUG program, begun in 1990, is "a care coordination program for at risk pregnant women, infants, and children up to age five years," and was created in response to a growing concern for the health and related needs of Nashville's underprivileged families.

The goals of the HUG program are to optimize the growth and development of infants and young children; to reduce infant mortality, morbidity, and low birth weight; to ensure families and children have access to health care (including prenatal care and mental health care); to reduce risk behaviors among family members; and to ensure that social, educational, and financial needs are addressed.

In order to meet these goals, the HUG program provides the following services:

- Assisting with establishing insurance coverage and then establishing and maintaining a medical home;
- Teaching the importance of preventive health care such as well child check-ups, immunizations, prenatal care, and family planning;
- Following up on missed medical appointments;
- Assessing the health, growth, and development of infants and children and making referrals for early intervention and other services as needed;



Alexandria Swindle with nurse Ruth Ann Barr



Tuyet Do, Ngoc Le, and Binh Do visit with Ruth Ann Barr.

- Teaching basic parenting skills such as newborn/infant care, feeding and nutrition, parent/infant bonding, appropriate discipline, and child safety; and
- Assisting clients in accessing community resources and building self-reliance skills.

HUG services are delivered by health care professionals such as registered nurses, social workers, or social counselors. Once an "at risk" family is identified, referred, and enrolled, the health care professional then delivers services through ongoing visits to the client's home. These home visits may be made on a weekly basis or a monthly basis, depending on what specific needs each family has. Together the client and care coordinator come up with specific goals to eradicate or minimize problem areas and to promote health and well-being. These are outlined in the client's "care plan."

Since the program began, more than 2,400 families have received HUG services, and the outcomes for clients completing the program prove that a positive difference has been made! Last year (FY 2002), 76% of HUG graduates completing the program were up to date on their immunizations compared to 62% of those still enrolled. Eighty-one

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percent of graduates were up to date on their well child examinations compared to 70% still enrolled, and 69% of graduates had utilized early intervention services compared to 50% of those enrolled.<sup>1</sup>

While these results are encouraging, there are still many Davidson County families in need of help. Last year, the statewide program was re-titled "Tennessee Home Visiting" and the program's focus shifted slightly. But here in Nashville, one by one, HUG strives to do its part to make a happier, healthier tomorrow for each parent and child, one step at a time, and to make sure that there are always plenty of HUGs to go around!

For more information about the HUG program, contact Sandra Kaylor, Program Director, at 615-862-7942.

#### Reference:

- <sup>1</sup> Kaylor, Sandra. "Fiscal Year 2002 HUG Closure Summary Report." Metropolitan Public Health Department's HUG Program. Unpublished data kept by the Program Director.



DeAnthony Inman enjoys a home visit with Ruth Ann Barr.

# Healthy Start of Nashville

Peggy Cox, RN, MSN, Director of Healthy Start Nashville

The Healthy Start Program was mandated in Tennessee by the Tennessee Early Childhood Development Act of 1994, spurred by the success of the original Healthy Start Program in Hawaii. It had demonstrated decreased incidences of child abuse/neglect, increased immunization rates for young children, increased early prenatal care for subsequent pregnancies, and detected and remedied developmental delays early in young children for Healthy Start participants. The Act specified that the services in Tennessee be offered voluntarily, be focused on home visiting and counseling services, on improving family functioning, and on eliminating the abuse and neglect of infants and young children within families that are identified as high risk. This same legislation specified an ongoing evaluation be performed on the program, and the College of Social Work Office of Research and Public Service (SWORPS) at the University of Tennessee in Knoxville was contracted for this. The evaluations and actual intake of families began in 1995. The University SWORPS team continues to do quarterly and annual evaluations on all of Tennessee's eight project sites, one of which is Healthy Start Nashville.

Healthy Start of Nashville began organizing in the fall of 1994 and admitted its first families in the spring of 1995. Today it consists of twelve dedicated health professionals whose mission is to promote a healthy start for first-time parents and their babies, and to prevent child abuse and neglect in at-risk families in Davidson County. The program is funded by a continuing grant from the Federal Maternal Child Health Bureau and is administered through the Tennessee Department of Health. The Nashville site is the only one that is located in a local health department and the only one with nurses among the home visitors.

## Purpose

Healthy Start is designed to support new parents by providing resource information as well as education regarding child safety, child health, disease prevention, child development, and parenting skills. Through these efforts it is hoped that the stress involved in new parenthood can be decreased.

## Objectives

1. Identify first-time, overstressed families in need of support;
2. Reduce family stress and improve family functioning;
3. Immunize all children by their second birthday;
4. Perform developmental screening (Denver II is used) and follow-up services;
5. Demonstrate increased parenting knowledge and skills; and
6. Keep children free from abuse and neglect.

The approach used in the Healthy Start model is strength based, including a lot of appropriate praise, goal setting, and focusing on parent-child interaction. Nashville's goal is to offer parents most in need of services intensive long-term (3 – 5 years) support, building on the family's

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strengths. Program focus is on the entire family, particularly enhancing family functioning, healthy parenting, and child development in order to prevent crises and meet needs early.

At this time, the team here in Nashville has three Public Health Nurses and seven Outreach Workers who provide family support service through home visits to qualified families wanting the services. In the program they are identified as Family Assessment Workers and Family Support Workers. Criteria for referral to the program are: a first-time prenatal woman, a first baby through 3 months of age, and a resident of Davidson County. Each referral is assessed using a specific tool called the Kempe Stress Check List to determine eligibility related to a number of stressors and risk factors scored on a standardized scale. Once a family enters the program, the team member assigned to the family works with them making home visits beginning weekly with specific criteria for changing the intensity of visits in order to:

1. Strengthen and support new families;
2. Provide education and information on bonding, basic infant/child care, and safety;
3. Perform regular developmental screenings and educate on appropriate toys/books/activities to stimulate mental, physical, and emotional growth;
4. Assist fathers in supportive activities;
5. Link new families with medical providers for preventive health care;
6. Link new families with appropriate community assistance/resources programs; and
7. Work with families to reduce health risks and increase parenting knowledge and positive parenting skills.

Statistics from the annual report for the fiscal year 2000 – 2001 compiled by the SWORPS team reveal the following demographic data about the Nashville participants.<sup>1</sup>

#### **Age of Healthy Start Mothers**

14 and under	12.5%
15 – 17 years	44.1%
18 – 19 years	15.8%
20 – 24 years	17.3%
25 – 29 years	2.2%
30 – 34 years	4%
35 or older	4%

#### **Race of Mothers**

African American	64.6%
Hispanic	3%
Asian	0.4%
Caucasian	29.5%
Other	2.5%

#### **Educational Status of Mothers**

Under 12 years	74.5%
12 years or GED	31.5%
13 – 15 years	9.5%
16 years or more	1.8%

#### **Annual Income of Mothers**

\$0 - \$10,000	97.8%
\$10,001 - \$20,000	1.1%
\$20,001 or above	1.1%

#### **Age of Healthy Start Fathers**

14 years and under	1.6%
15 – 17 years	22.5%
18 – 19 years	21.9%
20 – 24 years	29.9%
25 – 29 years	10.2%
30 – 34 years	4.8%
35 or above	9.1%

#### **Race of Fathers**

African Americans	69.5%
Hispanic	6.9%
Asian	0.8%
Caucasian	20.6%
Other	2.3%

#### **Education of Fathers**

Under 12 years	56%
12 years or GED	33.3%
13 – 15 years	8.3%
16 years or more	0.8%

#### **Annual Income of Fathers**

\$0 - \$10,000	84.2%
\$10,001 - \$20,000	12%
\$20,001 - \$30,000	2.2%
\$30,001 or above	1.5%

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Progress toward meeting several specific objectives for the Healthy Start Program in the year 2000 – 2001 are reported by the evaluators as:

- 97.1% of two year olds are up-to-date on immunizations
- 94.1% of two year olds are up-to-date on well-child screenings
- 88.2% of two year olds are up-to-date on developmental screenings
- 99.5% of all program children were considered abuse/neglect free
- 77.2% of mothers with subsequent pregnancies received prenatal care in the 1<sup>st</sup> trimester

The majority of the Nashville program referrals come from the local hospitals through the Metro Public Health Department's Central Referral System. However, they can come from other agencies, doctors' offices, friends, and the families themselves through the same system. During the 2001 – 2002 fiscal year, the program team served 350 families making a total of 4,976 visits. The monthly family caseload for Healthy Start Nashville is about 190 families total. The new statistical data from the SWORPS evaluators of all the programs statewide for the fiscal year 2001 – 2002 should be out by November, and will be available for review. It will give the updated data on these current and more recent participants.

For more information about Healthy Start Nashville, contact Peggy Cox at 615-880-2159.

Reference:

<sup>1</sup> Tennessee Department of Health. *Healthy Start Annual Report 2000 – 2001 (July 1, 2000 – June 30, 2001)*. Prepared by the University of Tennessee. College of Social Work. Office of Research and Public Service.

## A Healthy Start Success Story: Samantha and James

Antrion Washington, Outreach Worker, Healthy Start of Nashville

Throughout my seven years with Healthy Start, it has been a learning experience for me as well as the families. Parenting isn't an easy task, but being able to work together with others can increase your knowledge. We have plenty of educational material and training to help us do a better job. Being able to discuss issues with co-workers is helpful also. I try to enlighten the families on becoming self-reliant and motivate them to know that they can reach goals beyond their understanding.

One of the families I have had the pleasure to work with for over a year is a young married couple age 18. Samantha and James have a daughter age one named Vickie. They have both been present most of the time throughout each home visit. They have shown a lot of love toward their daughter since the very beginning. Samantha and James know that family time is important. James has been a great provider for his family. His grandmother has been very supportive along with his younger sister and brother. Each of them is able to share their love with Vickie and of course, playtime.

Samantha decided to go back to school this fall after having to drop out last year because of medical reasons. Education is important to Samantha. She doesn't plan to let being married and having a baby stop her from getting an education. The baby attends the daycare where Samantha goes to school.

I am truly convinced that Samantha and James will look back on their life and wonder how they made it through. The Healthy Start Program knows that praise and determination will take you a long way. I feel that this family is already on the path and will meet future challenges with the same energy and enthusiasm.

## Healthy Start Success Story: Mamie

Katherine Mumphrey, Family Support Worker, Healthy Start of Nashville

Five years ago, I met a 38-year-old mother who had gone through some rough times. Mamie was a single mother willing to learn any and everything about parenting. Mamie decided that since she "birthed this child into the world," she had to do her best to make sure he had everything he needed. Mamie had the help of her older sister Grace, also.

Mamie had set several goals throughout the five years that she was in the Healthy Start Program. One of the biggest goals was to sell the home that she had inherited from her parents and move into a nicer place. The house she owned needed a lot of repairs, so she thought about it and decided it would benefit her and the baby more if they moved out. The house was in an area where Mamie did not want the baby to grow up.

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Mamie did not feel that it was the safest part of town. Mamie made a big adjustment moving from North Nashville where she was born and raised to South Nashville.

Upon moving to South Nashville, Mamie accomplished her second goal, which was to get her son Joshua into daycare. Mamie enrolled Joshua in Bethlehem Center and became an active parent. Mamie was the secretary of the parent association. While Joshua was in daycare, Mamie took classes that would benefit her future. Mamie completed computer I and II classes.

Joshua has now graduated from daycare and is attending kindergarten at Napier School. Mamie is trying to enroll in a Certified Nursing Technician (CNT) class. She has also met a man whom she plans to marry soon. Her future is looking much brighter. Mamie gives the Healthy Start Program a lot of credit for her success. I give it back to her because she was willing for 5 years to let me come into her home, and we both worked hard together to try and give Joshua a Healthy Start.



From left to right: Mamie, Katherine Mumphrey, Joshua, and Barbara Simpson, RN

## Mamie Talks about her Healthy Start Experience...

*Each individual person that becomes a parent for the first time is a candidate for Healthy Start. What does that mean? Whether you are male or female, you are a parent with strong and serious responsibilities to your child, as well as to yourself.*

*It can be a frightening experience but I've had a great opportunity to have guidance, strength and clear understanding to help raise and train my child. This has been through the help of the Healthy Start Program.*

*With this experience, I've also learned and grown to understand my child's growth and abilities with prayer and patience.*

*Our children grow so fast. We have to learn to grow along with them and with understanding.*

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# Healthy Start Success Story: Joy and Fred

Linda Shaw, RN, Healthy Start of Nashville

*I'm still in awe of the person I consider to be my most inspiring, unique, and accomplished Healthy Start Program mother. Joy is now 17 years old and the mother of 2 children, 4-year-old Bianca and 4-month-old Brianna. Joy lives with her fiancé Fred (the father of the children) whom she plans to marry after her 18<sup>th</sup> birthday. She has been emancipated since age 16. Joy just moved into her second apartment since her emancipation. The first was subsidized housing at age 16. Joy proudly announced that she and Fred chose to move to the new housing without assistance. They both work and pay the nearly \$600.00 a month rent (utilities not included) for the newly renovated 3-bedroom apartment in a nice gated community.*

Joy works full time as a Certified Nursing Technician (CNT) in a local nursing home. She plans to pay her own way through nursing school (her primary goal), rather than accept offers from her current employer to fund the expense. Joy states that she doesn't want to be obligated to work for them only after graduation.

Joy is now breastfeeding her second baby (just as she did her first for over a year). Bianca, her 4-year-old will be entering Head Start this fall. The couple kept Brianna at home with alternating work schedules, and Fred's sister also helps with baby-sitting. Fred drove up in her new car on my last visit, the third car that she has owned and purchased for herself since age 15. I congratulated Fred as I was leaving on his recent job commendation, the couple's many accomplishments, as well as their plans to get married. As I exited the gated apartment complex with its nicely manicured landscaping, I could not help but reflect back over Joy's life and remember the timid 13-year-old that I first met over 4 years ago.

It has not always been so easy for Joy. Upon discovery of her pregnancy, her mother sent her to live temporarily with her maternal grandfather in a very crowded, but neat, 1 bedroom apartment. She promised Joy that she would find new housing and send for her later, but that never happened. Joy was very self motivated and strived courageously during her later pregnancy, along with her apprehensive but supportive grandfather.

I visited Joy many times after school and found her sitting on her bed in the crowded living room doing her homework or breastfeeding her baby. Joy attended school every day and continuously made the honor roll (sometimes all A's) while taking care of her baby all alone. I'd often leave with a request to drop a letter in the mail to Fred, who was in a youth correctional center.

Joy's baby could not have asked for a more caring and attentive mother. She immediately began breastfeeding and set her up for daycare including transportation, soon after school started back, so she would not miss much school time.

As a 13-year-old, Joy kept Bianca's medical appointments and took good care of the baby without family assistance, except her grandfather's providing her a place to stay. The rest Joy did on her own.



Fred, Joy, and Bianca



Brianna

I visited Joy weekly and provided parenting education, guidance, and other support as needed. I was always careful to praise her for her many accomplishments and to encourage her along the way—always letting her know that she could do it!

The next summer when Joy was 14, she could not wait to work her first job at a summer youth program. She also worked at Bianca's daycare center when the summer program ended. In November of 1999, Joy made her re-acquaintance with her stepmother (encouraged by her biological father who was in Nigeria). Her stepmother helped Joy towards independence by getting her a job at a local hotel as a hostess and teaching her the value of hard work and having things. Joy also got a second job at a fast-food restaurant, while still taking care of Bianca and making good grades in school. She quit the fast-food restaurant when they asked her to work days. Joy continued her job at the hotel and eventually began cleaning hotel rooms, which allowed her to make even more money. She stayed with her stepmother and siblings during the summer of 2000. Joy bought her first car at 15 and got her driver's permit, before returning home with her grandfather for the school year. What an accomplishment for a young mother! Now she could drive herself to school and to work.

By this time, Fred was home from the correctional center. He lived with a single mother and had no positive male role models. Joy told him that he had to get a job if he wanted to

follow her, or she would be leaving him behind.

When Joy was 16, she bought her second car and was eager to become emancipated and on her own. She went through a period of rebellion with her grandfather and no longer wanted to listen to his or her stepmother's guidance. Her grades were slipping in high school, and she had an "I don't care" attitude. Fred was placed in the correctional facility again. I watched Joy as she became hardened and disillusioned, even bitter and resentful at times of her mixed African heritage, as well as problems with people in general.

I reminded Joy that she had inherited her strong work ethic from her father and that she wanted to be a nurse just like him. He would often send for Joy to visit him in Nigeria but she refused. Also, his wife, who was also Nigerian, had contributed much towards Joy's independence. And her maternal grandfather had always been there for her.

Joy's outlook and respect towards others improved tremendously upon receiving her emancipation at age 16. She moved into her own apartment in May of 2001, along with Fred and their daughter, and soon bought her third car.

This young mother continued working and going to school, providing for herself, Fred, and their child. Fred struggled to find and keep employment. Joy did home schooling for a while, then decided to get her GED. (Fred had already obtained his high school diploma.) However, before obtaining the GED, she completed CNT training and got a better position at the nursing home where she still works. Joy loves taking care of elderly people and can't wait to get her nursing degree.

It's sad in a way to know that I will soon be losing one of my more successful participants as she approaches the end of her 5 years (grant completion) in the Healthy Start Program. It has been a great learning experience and extremely rewarding for both Joy and myself. I feel that we have taught each other so much. I know now that you can achieve virtually anything if you continue to try and never give up, in spite of what your odds may be. Joy is a living example of this and so is her companion. Joy was so determined to motivate him to come up to her standards and not lag behind. This couple is well on their way to becoming whatever they want to be. I will always wish them only the best.

### Healthy Start Teen Support Group

The Healthy Start Program is organizing a support group for Healthy Start teenage mothers between the ages of 13 and 17 years.

These moms will have an opportunity to spend time with other teen parents, share their concerns and insights. They will be given pertinent information concerning the responsibilities and challenges of teenage parenthood and how to effectively deal with them.

The first meeting was held in August. For information about the support group including scheduled meeting times, contact Peggy Cox at 615-880-2159.

# Baby Baskets for Nashville

Peggy Cox, RN, MSN, Director of Healthy Start Nashville

The latest data available for Nashville reveals that the fetoinfant deaths numbered 243 during the years 1995 – 1997. Of these, 45 deaths were determined to be caused by Sudden Infant Death Syndrome (SIDS), “ill-defined” reasons, and “other” causes.

An article in the August 2002 *American Baby* magazine quotes the Consumer Product Safety Commission as announcing that 60 babies under two years of age die each year in adult beds, twice as many as die in cribs.<sup>1</sup> Though there is not firm information on how, exactly, all of these deaths occurred, here in Nashville there have been several infant deaths related specifically to co-sleeping, or sleeping in adult beds. Some babies have died from “entrapment” between the mattress and wall, or a part of the furniture; falls from beds; and suffocation in soft bedding. As if these causes of death are not sad enough, an even sadder means of infant death occurs from “overlying.” This happens when someone sleeping with a baby rolls over onto the baby and causes suffocation during sleep. The same article notes that 58 of the 180 infant deaths occurring in adult beds nationally in a three-year period were due to overlying.

The Metropolitan Public Health Department’s (MPHD) Maternal Child Health (MCH) Division and the Perinatal Periods of Risk (PPOR) Practice Collaborative Initiative are focused on ways to reduce the infant mortality rate in Davidson County. In a recent survey of Healthy Start mothers (190) who are currently co-sleeping with their infant or previously co-slept with their older children when they were 0 – 4 months of age, it was found that about 72 of the current program infants/children were in this high risk category. A change is imperative!

Many of the MCH program parents cannot afford a bassinet or crib for their infants, and then, there are some who just want to keep their infant close to them as they mistakenly believe this will prevent SIDS or what they know as “crib death.”

The family home visitors from MPHD spend a lot of time educating on safe sleeping conditions, including “back to sleep” and the infant’s separate sleeping space free of possible “overlying” or any materials that can cause suffocation. They also spend extra time and effort trying to locate appropriate used bassinets or cribs for donation to families who cannot afford these necessary items. Needless to say, this proves very frustrating and frequently impossible.

Several months ago, in reviewing articles in a medical periodical, the write-up of a special program called “Project Moses” that was started in Collier County, Florida was discovered.<sup>2</sup> A public health nurse visiting families with similar financial and space problems there, as those seen regularly here in Davidson County, worked with her church to start this program. It consists of making and distributing a container that is covered and prepared for use as a bed for infants up to 3 – 4 months of age. The nurse’s name is Carol Tighe, and the baskets are distributed there through the birthing facilities, the children’s medical centers, the church, and the home visitors. The project began in the county in 1999, and there have been 150 baskets distributed each year since that time.

Nashville babies need the same love and concern from their community. They don’t need to die from these preventable causes. Materials have been priced and patterns made to begin a similar program here in Nashville. However, at the

time of this writing, there has been no organization or church community located yet to assist in sponsoring and carrying out this project. It is hoped that this article may spark some interest in sponsorship. Remember, “It takes a village to raise a child.”

*If you are interested in more information about Baskets for Babies or are interested in sponsoring this project, contact Peggy Cox at 615-880-2159.*

## References:

<sup>1</sup> Beam C. Should you share your bed with baby? *American Baby*. 2002: Volume LXIV, Number 8.

<sup>2</sup> Tighe CM. One nurse takes action to prevent infant deaths. project moses. *MCN: The American Journal of Maternal/Child Nursing*. July/August, 2001;26(4):217.

# Children's Special Services

Sheila McCloskey, RNC, BSHA

The Children's Special Services Program (CSS) began in theory as "Crippled Children's Services" in 1923, following the organization of the Tennessee Society for Crippled Children that same year. It was quite rudimentary and relied heavily upon services provided through the first Crippled Children's Hospital in Memphis, TN, which had only begun operation there as of 1919. The program only provided children and their families with free access to specialist care by physicians, which at that time, consisted primarily of orthopedists. Six years later, with the passing of the Crippled Children's Act of 1929, diagnostic and operative clinics were authorized and administrated by the state for the benefit of crippled children (still mostly with orthopedic problems). As services for these children appeared to be improving, the stock market crash of 1929 hit with a bang, seceding the function of CSS from 1931 to 1935.

It was in 1935 that children's access to medical services made both pivotal and historic progress, with the passing of the Social Security Act of 1935, which made federal funds available to CSS for the first time as of 1936. Through the next several years, the program was more fully developed, with services offered across the state, to children ages birth to 21 years whose families were financially in need. As the number of children referred increased, so did the awareness of the need for assistance with speech and hearing defects. A screening program was begun in 1951, which was started solely for children with speech and hearing defects. As the need for this program grew, limited services were added to the indigent population until, in 1953, this became a separate program with its own guidelines. This move found CSS, again, primarily providing services to children with orthopedic needs.

It was not until 1961 that the state legislature revised and broadened the definition of the specific chronic medical problems that were covered under CSS. This expanded coverage to children with diagnoses such as cancer and diabetes and led to monumental program growth. The program as a whole now served the entire state of Tennessee, with many varying sources for referrals. It was still accepting children up to age 21, but more definitive financial guidelines were needed. In an effort to better streamline the referrals and serve more than just the indigent population, CSS established 150%

of the Federal Poverty guidelines as its formula for financial acceptability to the program. Also, in 1988, pediatric clinics became the main entry point into the CSS program. Soon, case management was increasingly necessary as children with varying and more intense kinds of illnesses were born and as society progressed towards a more complex variety of social issues. That same year, 3 pilot projects began regarding care coordination for families. Davidson County was one of these sites. Care coordination services were then established statewide. In November 1991, Davidson County assumed the responsibility of administering the CSS program for Davidson County residents, with the other counties across Tennessee following suit in the ensuing year. When the change over from the state Medicaid program to present day TennCare took place in 1994, CSS was forced to change its course of action. Since TennCare was mandated to cover all children to whom any other type of insurance was inaccessible, CSS took more of a back seat approach, being in many cases, the secondary provider.

Today, the program is titled Children's Special Services. It still serves children birth to 21 years, but encompasses a vast array of diagnoses, conditions, and syndromes that are considered chronic and whose needs are always changing as our society evolves. Referrals come into the program's screening and intake person from a variety of sources including doctor's offices, parents, social workers, extended family members, preschool programs, as well as other departments within the health department itself. The CSS of 2002 pays out of pocket medical expenses a parent may incur related to the needs of a chronic illness, disability, or special health care need, not otherwise covered by primary healthcare insurance or TennCare. The program does not presently cover any of the psychiatric diagnoses, Attention Deficit Hyperactivity Disorder (ADHD), or autism. It does commonly pay for medications, therapies, or procedures not paid for by any other means, either as a supplement (for example it may cover the 20% not paid for by insurance), or in the bill's entirety (100% of a request excluded by another policy) and in some cases for adaptive equipment and translator services as needed. It includes the appropriate level of care coordination needed in order to maintain the best possible medical treatment and maintenance for the children accepted to the program. The care coordination component of CSS begins when the family first applies for the program. The care coordination component provides assistance that ranges from helping with the application to assessing the needs of the family, which generally includes many other problems related to having a special needs child. Some of their responsibilities may be helping to schedule medical appointments, talking with professionals, helping

*continued on page thirteen*

the family understand basics about diagnosis and treatment, attending and providing input on an educational plan of care, helping complete an Supplemental Security Income (SSI) disability or TennCare application, or even connecting them to resources like Special Olympics. CSS offers a full audiological evaluation for children as well as services to both provide and care for hearing devices a child may need. The speech component also provides evaluations to children under age 3, but more importantly, the therapy that is sometimes so desperately needed. It also includes connections for those children and their families to various resources and support systems.

Through CSS, the Parents Encouraging Parents Program (PEP), a free statewide parent-to-parent support and information network, evolved in 1993, employing parents of children with any special healthcare need as a means of emotional support to other parents. This element of CSS has no financial or age guidelines and is also supportive of professionals who are trying to provide services to a child with a special need in the way of diagnostic resources or information. PEP supports parents by helping them keep abreast of current research information and by helping them with opportunities to be an active part in decision-making situations regarding children with special health care needs.

What is the future of CSS? With the financial criteria recently increased to provide coverage to families under 200% of the Federal Poverty guidelines, the program promises to reach out and assist more families each year. TennCare policy changes, however, as well as private health insurance policy changes will continue to dictate specific provisions offered by Children's Special Services. As a federally funded grant program identified as a third party payor, effective coordination and timely responses will continue to be crucial in providing gap services to the disability community. We look forward

to not only continuing coordination with various insurances, but look forward to doing so with an enhanced effort toward establishing valuable and mutually beneficial relationships among other existing community agencies.

*In order to obtain more information about Children's Special Services, contact Sheila McCloskey or Patricia Khalil at 615-340-5697.*

## Care Coordination

Julia Ridings, RN; Sarah Thorpe, SW; Mary Koob, RN

Care coordination, provided by nurses and social workers, is the component of Children's Special Services (CSS) that has face to face contact with the families who have children enrolled in the CSS program. It is the responsibility of the care coordinator to meet with the parent or family in the home, if this is agreeable, to assist in the initial application for CSS and thereafter yearly to recertify for CSS.

Care coordination (CC) is available to all children who are eligible for CSS. However, some children who are ineligible for medical services may be eligible for CC. Contacts by phone or home visit to the family may be as often as, but not limited to, every three months to as infrequently as once a year. Families are encouraged to contact their CC between scheduled contacts as the need arises. There are difficulties inherent to CC, such as lack of providers, reimbursement for services issues, and imperfect systems of services to work through. Probably, the greatest challenge to a care coordinator's efforts to assist a family is the family whose priorities are frequently changing.

Care coordinators in Davidson County are very fortunate to have an audiologist and two speech therapists in the CSS office to make referrals to and who are readily available for consultation. It is rewarding to the care coordinator to know that he or she has participated in a positive outcome for a client's circumstances or health. Consider the following examples:

One CC recently spent hours of personal time attempting to obtain dental care for a teenager who didn't seem to meet the criteria to get care by any of the insurance providers. That mission was finally accomplished and a milestone in the health of this child who had never before received dental care was met.

The CC of another family was invited by the mother to attend a multidisciplinary meeting for her child at his school. The CC attended but the mother did not due to several circumstances. The principal was present at the meeting. She arranged a home visit by the teacher to go over the child's Individual Education Plan (IEP) with the mother. This probably was the result of the CC being present and showing interest in the child and his activities at school. In the past, copies of the IEP were sent home to this mother to sign and return. Hopefully, this was a positive outcome for the teacher, parent, and child.

*continued on page fifteen*



# Parents Encouraging Parents

holly lu conant rees, Parent Consultant

**W**hen parents learn their child has a disability or chronic illness, they are suddenly catapulted into a frightening and unfamiliar world. The most basic assumptions a mother or father has—that you can hold your baby, that your child will walk and speak and grow—are perhaps no longer valid. That parent is confronted daily with a powerfully disturbing mix of emotions, including fury, guilt, and sorrow, which don't fit the typical model of the parent-child bond.

Parents of typical kids have a huge grapevine of formal and informal information to guide them in child raising: family anecdotes, developmental timelines, and whole shelves at the bookstore. A parent of a child with special needs has no such body of collective wisdom from which to draw. Physicians and other professionals can give diagnoses and prognoses. But when the questions are “How do you dress a baby in a body cast?” or “Will other kids tease her?”, parents of children with special health care needs don't have a Dr. Spock of disabilities available for answers.

has reached and supported hundreds of families with situations ranging from a prenatal diagnosis, to an adult son or daughter who is moving into the community with supported employment. Each of these families has their own unique story, with a powerful message of hope and strength. One recent encounter, though, epitomized the difference that PEP can make in a family's life.

A woman approached one of our parent consultants at a recent conference. She began by saying, “I'm sure you don't remember me,” although we did. She reminded us that we had connected her family with another young family whose child had the same diagnosis as her son. The two couples became fast friends, as did the two boys. The family with whom she'd been connected

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***PEP is founded on the belief that families deserve access to accurate, appropriate information, which enables them to become empowered as partners in their child's care.***

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Parents Encouraging Parents, (PEP), is a support and information network for families who have a child with any kind of disability, chronic illness or special health care need. While the PEP program is under the auspices of Children's Special Services (CSS), there are no financial, age, or diagnostic eligibility criteria for accessing our services, which are always provided at no charge.

PEP is founded on the belief that families deserve access to accurate, appropriate information, which enables them to become empowered as partners in their child's care. PEP has an extensive print and video library, as well as comprehensive resource files of diagnosis-specific information, listings of local and national resources, and materials on issues pertinent to the care of children with special health care needs.

Experienced parents can offer an insider's guided tour to the world of parenting a child with a disability or chronic illness. PEP parent consultants and volunteer support parents provide one on one peer support to family members of a child with a new diagnosis or who is in a crisis or transition situation, or who are simply in need of additional support or information. Many of the calls to the PEP office are from families who are struggling to make their way through “the special education maze,” and our staff often can help resolve complex situations through our firsthand knowledge and expertise.

PEP's goal is to share information, coping strategies, and encouragement with families who are just beginning to meet the challenges of life with a disability within the family. In the network's nine-year lifespan, PEP

moved out of state several years ago, but they stayed in close contact. She ended the story—although the story really will continue on—by telling us that her son was going to stay with the other family for two weeks, so that for the first time since their son had been born, she and her husband could take a trip and spend some adult time together. “And it's all because of PEP.”

Her story underscores the vital importance of parent-to-parent support. Connecting with another family, who lives on this same strange planet of parenting a child with a disability, can be a life-changing experience, offering the gifts of hope and community. Parents Encouraging Parents provides the opportunity for meaningful, respectful support, sending the message that no family has to make this journey alone.

*For further information about Parents Encouraging Parents, please contact Patricia Khalil at 615-340-5699.*

## "Let the Circle Be Unbroken: Caring for Children with Special Health Care Needs"

holly lu conant rees, Parent Consultant, Parents Encouraging Parents (PEP)

The first ever conference sponsored by Children's Special Services (CSS), "Let the Circle Be Unbroken: Caring for Children with Special Health Care Needs," attracted over 100 attendees. The enthusiasm and appreciation of the participants, both service providers and family members, made it apparent that this event will indeed be a "first" in a series of much needed community forums focused on children with special health care needs (CSHCN) and their families.

"Let the Circle Be Unbroken" was held May 2, 2002 at the downtown public library. So many of those in attendance commented on the splendid renovation of the building that a tour of the facility may be added to next year's agenda. While experiencing a few small kinks with parking and arctic temperatures, nearly all of the respondents to the evaluation questionnaire agreed that the location was convenient and comfortable.

The morning program offered a range of perspectives on the current status of CSHCN and their families through the lens of the six Healthy People 2010 goals targeted to this population. Dr. Kimberlee Wyche-Etheridge provided an overview of the goals, also referred to as the "2010 Express," enlivened by vignettes of children with whom she has worked. Jennifer Cernoch, Executive Director of Family Voices, a national grass roots network which advocates on behalf of CSHCN and their families, presented an informative and entertaining keynote on national level issues, drawing from her years of experience in the field. Joe McLaughlin, Director of the Healthy Children initiative; Greg Yopp, state CSS Director; and Steve Camarata, Interim Director of the Kennedy Center shared useful, up to date information from their areas of expertise.

Afternoon sessions included a choice between two panels: one oriented towards early intervention and school age issues; the other focused on the transition into adulthood of adolescents with chronic conditions. Following the panel presentations and lively question and answer sessions, participants selected one of several topics, such as autism spectrum disorders or cultural competence for small group discussion. Key comments from these energetic roundtables will be compiled into a summary document for distribution to all involved.

With nearly two dozen exhibits from community agencies and organizations, as well as a delicious breakfast and lunch (sponsored respectively by the Wild Oats Market and the Vanderbilt Children's Hospital Department of Pediatrics), the conference was a jam-packed full day, offering information, sustenance of several varieties, and networking opportunities. One participant expressed the wish that the conference would continue all weekend.

CSS and PEP staff, with strong support from the Steering Committee, especially Jan Rosemergy from the Kennedy Center, were proud and delighted by the positive response to their hard work. Discussion has already begun around next year's sequel, with a particular goal of attracting more family members. *If you have suggestions for speakers, topics, strategies, or if you would like to be involved in the 2003 planning process, please contact Sheila McCloskey at 615-340-5697. We will continue our work to ensure that the circle of care for children with special health care needs and their families, indeed remains unbroken.*

Another CC made a visit to the home of one of her clients who had several siblings. While there, she noticed that several of the children had extensive rashes. Although there was a significant language barrier, she arranged to have them seen by a physician and accompanied them to the appointment. They received treatment for their extensive impetigo. Since that time, the family has appeared several times in the CSS office seeking that CC for assistance.

It is not unusual to get phone calls and sometimes letters from families expressing gratitude. One letter was received written by a child who has phenylketonuria (PKU) thanking us for the variety of foods that were provided to him through CSS. He stated that was the first time he had ever eaten cheese. This is a sample of CC experiences and outcomes to services.

Care coordination services may include the following:

- Assist families with understanding and meeting insurance/TennCare requirements for service (prescriptions, letter of medical necessity, appeals);
- Accompany families to appointments when requested;
- Assist to obtain information about diagnosis if needed;
- Promote continuity of care among providers of services;
- Help families to be an effective manager of their own care;

*continued on page twenty-one*

## Speaking Out about Speech and Language

Beth Ladd, MS, CCC/SLP and  
Luwana Ralph, MS, CCC/SLP

**C**ommunication allows children to interact with the world around them. Children are born with the potential to learn to understand others and to express themselves. Receptive and expressive language, articulation, and fluency are some of the components of communication that begin to develop early in life. However, some children do not acquire the skills needed to be effective communicators.

According to the American Speech-Language Hearing Association, approximately 6 million children under the age of 18 in the United States have a speech or language disorder. Almost two-thirds of this population is male.<sup>1</sup> The Tennessee Department of Education has compiled the following statistics for the 2000 – 2001 school year:

- 23.4% (40,826) of students receiving special education services in Tennessee qualified as speech or language impaired and
- 23% (2,749) of special education students in Davidson County were eligible for speech or language services.<sup>2</sup>

The Speech Clinic at the Metropolitan Public Health Department evaluates and treats children ages birth to three years. Referrals come from doctors' offices, early intervention agencies, and families in the community. The clinic, staffed by two speech-language pathologists, has evaluated 229 children since January 2001 and conducted 1,168 individual therapy sessions in the same time period. A 36% increase in visits provided was noted during the first half of 2002.

Speech and language skills play an important role in learning and academic performance. Speech-language services can help children excel educationally and socially. And the chance to succeed is something that every child deserves.

### References:

<sup>1</sup> American Speech Language Hearing Association website. Available at: [http://www.asha.org/speech/development/schools\\_faq.cfm](http://www.asha.org/speech/development/schools_faq.cfm)>. Accessed on September 25, 2002.

<sup>2</sup> Tennessee Department of Education website. 2001 Annual Report. Available at: <http://www.state.tn.us/education/01fannualreport.pdf>. Accessed on September 25, 2002.

## Turn the Page Together

Luwana Ralph, MS, CCC-SLP and  
Beth Ladd, MS, CCC-SLP

**T**urn the Page Together is a pilot community outreach project that focuses on promoting literacy in young children. The program is being developed by the staff of the Speech and Hearing Clinic at the Metropolitan Public Health Department. Luwana Ralph and Beth Ladd, speech-language pathologists, have partnered with Luz Belleza-Binns, community outreach specialist, to highlight the connection between reading, communication, and parent interaction.

Books in both English and Spanish have been obtained from a variety of community resources such as local literacy agencies, public television, and private donations. These books have been divided into several categories: infant/toddler (age six months to three years), preschool (age three to five years), and elementary (ages five to ten years). When a child visits the clinic or receives a home visit, he/she will be given a grab bag containing developmentally appropriate books and parent information regarding reading and language development. Parent training materials have been acquired from the Department of Education, American Speech-Language Hearing Association, and Nashville READ.

The goals of Turn the Page Together are to place a book in the hands of every child who visits the clinic and to determine if suggested reading activities were incorporated into the child's daily routine. If initial outcomes are promising, then the program will expand to include all programs serving children within the Metropolitan Public Health Department.

*If you would like additional information about Turn the Page Together or would like to donate books to the project, contact Luwana Ralph or Luz Belleza-Binns at 615-340-7785.*

### Literacy Facts

- Less than half of families read to their kindergarten-age children on a daily basis.
- In 1999, only 53 percent of children aged 3 to 5 years were read to daily by a family member.
- From 1983 to 1999, over 10 million Americans reached the 12th grade without having learned to read at a basic level. In the same period, over 6 million Americans dropped out of high school.

Source: Reading is Fundamental website: [www.rif.org/news/literacyfacts.htm](http://www.rif.org/news/literacyfacts.htm). Accessed on October 14, 2002.

# Tennessee Newborn Hearing Screening Update

Rachael Durham, MA, CCC-A,  
Audiologist

Great strides are being made regarding the Tennessee Newborn Hearing Screening Program (NHS) and the Early Hearing Detection and Intervention Program (EDHI). Guidelines are now being set, protocols are being written and revised, easy to read and complete forms are being developed, and funds are being offered to hospitals to purchase equipment for the purpose of testing newborns for possible hearing loss. The Newborn Hearing Screening Task Force, along with others, are working on developing simple, quick reference forms to promote accurate and quick data, in order for hospital employees who are administering tests and filling out forms not to lose interest. It is essential that hospitals take an active role in helping to identify any child with a possible hearing loss. Hospitals do seem to be jumping on board, and participating in the NHS and EDHI programs.

Thus far, the goals of the Newborn Hearing Screening Program consist of the following:

- Screen all newborns **prior** to hospital discharge or one month of age;
- Audiologic/diagnostic assessment **prior** to 3 months of age; and
- Intervention services **prior** to 6 months of age.\*

Many parents may ask their audiologists, physicians, or nurses why it is so important to have their child tested before they are even one year old. It is important to instill in parents with new babies how important, and in some cases crucial, it is to have your baby screened before he or she is discharged from the hospital. This is because newborns, regardless of

whether they are hearing or deaf, all babble and make vocalizations until they are 5 – 6 months old. It is not until after 5 – 6 months that the child stops babbling. At this point, it is a race against time to get the child identified for a possible hearing loss. The type of hearing loss needs to be determined. Research has shown that if the child identified with a hearing loss has intervention (is aided with one or two hearing aids), they have the best chance for developing on the same level or nearer to their peers. If the child is not aided until after 6 months, the child's development may be behind their peers, which can cause problems later down the road.

As of April 4, 2002, the total number of hospitals participating in Universal Newborn Hearing Screening (UNHS) was 59. Of that number, only one hospital screened high-risk infants. Thirty-one hospitals do not screen, which left the remaining number of hospitals that screened at only twenty-seven. The estimated percent of births in a particular region with access to UNHS are as follows:

- East Tennessee 97%
- Middle Tennessee 76%
- West Tennessee 88%

The percent of hospitals with UNHS per region are as follows:

- East Tennessee 85% (33 hospitals, 28 UNHS hospitals)
- Middle Tennessee 47% (36 hospitals, 17 UNHS hospitals)
- West Tennessee 64% (22 hospitals, 14 UNHS hospitals)

It is reassuring to know that an estimated 88% of newborns are born in a hospital that screens all babies (Universal Newborn Hearing Screening). It is estimated that 59 of 91 hospitals and birthing facilities in Tennessee now screen about 88% of all newborns prior to discharge!\*

This really is great news considering that just a few years ago not even half the hospitals participated in NHS and EDHI. Numbers of hospitals and birthing centers participating in NHS and EDHI hopefully will grow. There is still room for improvement and as long as babies are being born in hospitals with no screening prior to discharge, there will be babies who have not been identified with a hearing loss in a timely manner. Think of how much these babies could be missing. What if that was your baby? Would you want to know if he or she had a hearing loss as soon as possible?

*For more information about the Tennessee Newborn Hearing Screening program in Davidson County, contact Rachael Durham at 615-340-5697.*

\*Information and data taken from several communications between the Newborn Hearing Screening Task Force, Jacque Cundall with Central Children's Special Services at Tennessee Department of Health Cordell Hull Building, and the author.

# School Health Program

Martha Snow, MSN, RN, CS, School Health Coordinator

The current school health program celebrates its seventh year in 2002. Today, we have 53 registered nurses, two licensed practical nurses (LPN), and one support staff. We have added a pool of eight nurses who can be used on an as needed basis.

The first priority of the program is to provide nursing services to students who require medical procedures in order to attend school. Our second priority is to provide nurses to the Title I schools, which are schools that receive federal funding based on the number of students on the free lunch program. Sixty-seven schools have a nurse assigned to them every day for a portion of the day. The other schools have an assigned contract nurse for consultation who may be reached by pager.

With today's increasing technology, more students are able to attend schools pending nursing services. Currently, the program serves four students who have a tracheostomy. School nurses also have tube feedings, urinary catheterizations, and nebulizer treatments scheduled daily.

The number of diabetic students has increased dramatically from last school year. The school nurses visit 67 diabetic students every day and perform 88 scheduled diabetic interventions daily. With the rise in the occurrence of asthma, numerous asthmatics are assessed daily for peak flow monitoring and inhaler administration.

Although the school health program continues to be procedure driven, the nurses are engaged in numerous other activities in the schools. School nurses provide medication administration training in all Metro Public

Schools. School nurses collaborate with the Metropolitan Public Health Department's Immunization Program by performing school immunization audits, piloting a Hepatitis B Program in selected middle schools, and participating in the flu campaign. Numerous health promotion issues are addressed through the classrooms, staff in-services, or one-on-one consultation.

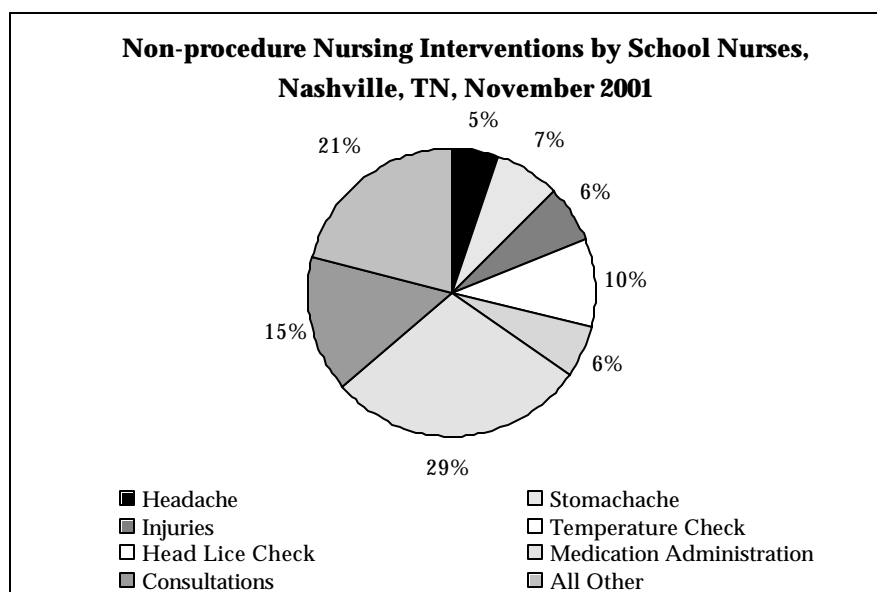
The focus areas for the 2002 - 2003 school year are diabetes, asthma, and obesity. Programs are currently under development in each of these areas for implementation this school year.

The school nurse program is an ever-changing program serving the public health needs of a wide population in Nashville. Most of the nurses would agree that school nursing is one of the most rewarding jobs in nursing.

*For additional information about the School Health Program, call 615-880-2138.*

## Leading Non-procedure Nursing Interventions by School Nurses in Nashville Public Schools for November, 2001

<u>Intervention</u>	<u>Total</u>	<u>Percent</u>
Headache	1,478	5.4
Stomachache	1,959	7.1
Injuries	1,733	6.3
Temperature Check	2,769	10.1
Head Lice Check	1,560	5.7
Medication Administration	7,943	29.0
Consultations	4,170	15.2
All Other	5,798	21.2
<b>Total Interventions</b>	<b>27,410</b>	





# A Day in the Life of a School Nurse

A Diary by Susan Spainhour, RN, School Nurse

**It's 7:30 a.m.** and the first visitor of the day has arrived at the clinic door. "I tripped running to the bus and scraped my knee." Sometimes ice is not enough to stop the tears, lots of reassurance that the bleeding will stop, and a Pokemon bandage help.

**7:45 a.m.** Cafeteria worker comes in, "I can't remember if I took my blood pressure medicine." A BP check and all is well, "call or come back if anything changes."

**8:00 a.m.** "I have a stomach ache!" Give a hug, take a temperature, ask if they had breakfast today...take through the cafeteria line or give a snack; send them on to class. Remind them to eat breakfast every day, being healthy is no accident. Five more come in with the same complaint.

**8:15 a.m.** Classroom visit for head check. Do lice ensure job security? Called to office, new student needs immunizations reviewed, keep those records up to date.

**9:15 a.m.** Glucose monitoring time, walk to the classroom and help with morning snack time blood sugar check.

**9:30 a.m.** What fun!! I am reading to a 1<sup>st</sup> grade class, "The School Nurse from the Black Lagoon." I get to teach hand washing, eating, sleeping, and ways not to spread germs, they get to laugh and take an AR (*Accelerated Reader*) test.

**10:00 a.m.** Clean intermittent catheter time. Sign goes on the door, office closed. Chat and listen to jokes while assisting as needed.

**10:15 a.m.** Oh, dear, someone needs a hug and a band aid because he didn't get one at home or needs a quiet place for a while, what is the problem, or is he collecting more frequent flyer miles...

**10:20 a.m.** Consult with physical education teachers about monitoring children with diabetes, asthma, and seizure disorders. Meeting in office with two teachers about ringworm and other rashes like Fifth disease, scarlet fever, tick, and spider bites. A walking encyclopedia!

**10:45 a.m. to 12:45 p.m.** Time for routine medications: Ritalin, Adderal, antibiotics, eye drops. Lunch

glucose check, carbohydrate count, give insulin, and document. Peak flows before recess and physical education. Check pollen counts and notes from moms. Three nebulizer treatments today; only two inhalers. Phone calls to parents, follow up on post tonsillectomy, pneumonia hospitalization, Fifth disease symptoms, strep throat. Fax orders to MD office.

**12:45 p.m.** Clean intermittent cath, document, update note home, pack supplies.

**1:00 to 1:30 p.m.** Catch up/finish charting and documentation...isn't paper pushing good exercise? Lesson planning time for Hygiene Class for third and fourth graders. Grab lunch at my desk.

**1:30 p.m.** Afternoon snack glucose check; a birthday party planned in the classroom. Calculate carbs of cupcake. More peak flows and inhalers and nebulizer treatments before PE (*Physical Education*).

**1:45 to 2:15 p.m.** Called to playground. Child fell off the monkey bars, head is bleeding, grab emergency bag, OSHA (*Occupational Safety and Health Administration*) and RICEing (*Rest, Ice, Compression, Elevation*) time. It stopped bleeding, phone call to mom. Head injury note home.

**2:15 to 2:45 p.m.** Oh, oh, "I slept too soundly and had an accident" clean and change. Distribute note home about lice in the classroom. Help with dismissal and return phone calls.

## The End of my Day!

Each day is different, but each day I learn something new, providing a multitude of nursing services to students, their families, and the faculty. Everyday I feel appreciated and needed in some way. **I love being a school nurse.**

*Items in italics added by the Editor to aid the reader.*

# Caldwell School Family Resource Center

Yolonda Radford, BS, Director

The Caldwell School Family Resource Center (FRC) is a center for neighborhood-based service delivery located in the Caldwell Early Childhood Center. Caldwell is a Title 1 school with kindergarten, a four-year-old pre-kindergarten program, and a three-year-old pre-school program located at 401 Meridian Street in the Sam Levy Homes public housing development.

The Caldwell School FRC has six major program goals:

1. To improve school readiness for the Caldwell School children through early identification and referral of social, health, developmental, and behavioral problems;
2. To assist parents and families to work toward solving problems that keep their children from attending and succeeding in school;
3. To assure access to health care services for at-risk pregnant women, infants, and children living in the Caldwell area;
4. To increase parental participation in school activities in order to increase their skills as parents and teachers;
5. To assist clients in the Caldwell area to access community resources and build self-reliance skills; and
6. To improve academic performance and self-esteem of Caldwell students at risk of failing.

To meet these goals, the staff at Caldwell FRC provides many valuable services for the school children and their families, as well as other families in the Caldwell community.

- Home visiting and case management services are provided for at risk pregnant women, infants, and children primarily living in census tracts 118 and 126 as well as those Caldwell students and their families with multiple needs placing them at highest risk for long-term problems in school performance. Referrals for these services may come from the school social worker, home school coordinator, teachers or other school faculty/staff, the Caldwell Clinic pediatric nurse practitioner, Vanderbilt mental health counselors, or the Central Referral System.
- Walk-in services for Caldwell School families including emergency assistance and referrals are provided when needed.
- Parent Club is a group of parents and other community members who come together weekly to share strengths, learn new things, and really make a difference in their children's lives. This year's sessions will deal with discipline, AIDS/STDs, depression, how to reduce stress, gang activity, coping with crisis, and good and bad touching. Parenting tips and handouts are given out weekly.
- Pat-a-Cake Class is a class for parents of young children addressing the growth and development of their children. This class meets bi-weekly.

*continued on page twenty-one*



Timothy St. Clair and Joshua Stubblefield work to learn numbers with the help of Yolonda Radford.



Yolonda Radford reads a story to a very attentive Antionette Dodson.

- Tutoring is provided for kindergarten children to give additional help and/or introduce them to the basic skills they need to improve academically and prevent failure. Also, each child is read to in the hopes of increasing their vocabulary and teaching them the joy of reading. Tutoring groups meet two to three times weekly.
- On-site nurses may assist with “emergency” head lice checks, faculty/staff blood pressure checks, or help ease the pain of minor scrapes and bruises that might occur in the clinic nurse’s absence.

The on-site director, Yolonda Radford, provides leadership and coordination of the team effort between FRC staff, school faculty, and the additional services located on site including the Caldwell Clinic and Vanderbilt counseling services. She also collaborates with many community partners including the Salvation Army Red Shield Family Initiative, which has assumed the role as the lead agency in the community, and the Northeast Nashville Family Resource Center. Partial funding for the Caldwell Family Resource Center is provided through a grant allocation from the Tennessee Department of Education and supplemented by the local Metropolitan Public Health Department budget.

For additional information pertaining to services offered at the Caldwell School Family Resource Center, contact Yolonda Radford at 615-291-6021.



Jamie St. Clair and Victor Brannon, members of the Parent Club, spend quality time at the Caldwell FRC.

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*Care Coordination...continued from page fifteen*

- Assist families to obtain special formulas and foods through insurance, TennCare, or CSS;
- Assist to obtain diagnosis information if needed;
- Provide information and referrals to various resources and services in the community; including Tennessee Early Intervention System (TEIS) and Tennessee Infants – Parents Services (TIPS);
- Assist families with written correspondence when requested;
- Attend multidisciplinary team meetings (IEP, Individual Family Service Plan [IFSP]) with schools, other departments, agencies, or providers;
- Make home deliveries of food and supplies when necessary; and
- Assist other family members as needed.

Care coordination can be obtained throughout Tennessee through the local health department. To access Care Coordination in Davidson County, call the Metropolitan Public Health Department at 615-340-5697.

# Families First Program

Nancy Ray, RN

The Families First Home Visitation program began in September 1996 in conjunction with welfare reform known as the Welfare to Work Program of Tennessee. The General Assembly of Tennessee passed Senate Bill #3151 on April 25, 1996, and the Families First Act of 1996 was approved by Governor Sundquist on May 13, 1996. The program is maintained by federal funds made available to Tennessee by Congress and the Federal Department of Health and Human Services. Section 5d (1) (B) of the bill mandates: *"Whenever temporary assistance for a family is terminated for any reason other than the family's successful transition to economic self-sufficiency, the Department of Human Services (DHS) shall promptly so notify the Department of Health. Upon receiving such notification, the Department of Health shall take appropriate actions to monitor and protect the safety and well being of the children within such family. Such departmental actions shall include, but not necessarily be limited to, one or more in-home visits with such children within thirty (30) days of the termination of such temporary assistance. Such in-home visits shall be performed by a nurse, medical social worker, or other health professional. In appropriate cases, the Department of Health shall make a referral to the Department of Children's Services."*

On the third working day each month, the process begins with receipt of the referrals from the Department of Human Services of all families whose welfare benefits have been terminated in the past thirty days. Referrals are sorted and batched by zip code, then looked up and registered into the Metro Public Health Department's (MPHD) data system. Immunization history and other MPHD services provided for the family, such as WIC, are noted with the referral.

The Families First staff then begins trying to make contact with the family by phone, letter, or home visit. A home visit is attempted with each family unless refused. When contact is made with the client, an Activity Report is completed which includes:

1. Financial information: What is the source and amount of gross monthly income and any housing and utility expenses? If income is less than unpaid monthly expenses, then the client is referred back to DHS for a possible auxiliary payment.
2. Food assessment: Is there adequate food to feed the children? Are children receiving WIC and Food Stamps?
3. Health assessment: Is the family obtaining healthcare services? Are children up to date on immunizations and well child exams? Are there any signs of abuse or neglect noted in the children?
4. Housing and utilities assessment: Evaluation is made of the type of housing such as public housing, subsidized housing, own, rent, living with friend or family member. Is the housing situation stable? Are the utilities working? Has the client received a cutoff or eviction notice? Are there any safety hazards in the home?

There is also space available for additional comments by the home visitor.

As the home visit and report are completed, any problems or needs identified during the visit are addressed by the home visitor. A directory

of resources is available so that we may refer families to whatever program or service they might need. This might include referral of the client for a food box, an auxiliary payment to keep utilities working, or for assistance obtaining money to pay past due rent. Financial concerns are only one of the problems we may encounter during a visit. There also might be a need to refer a client to a drug or alcohol rehabilitation program, domestic violence shelter, language assistance program, mental health services, support groups, or youth assistance support. One additional home visit may be made by the Families First staff if there are follow up concerns. All information is copied and sent to the Department of Human Services and the University of Tennessee School of Social Work for evaluation.

The underlying premise for the home visit program is that parents may become overwhelmed and stressed when their income ceases or decreases, or when a family is threatened with eviction or loss of utilities. They may be more prone to neglect the health and safety of their children, even possibly neglecting the children's basic needs. The health professional's visit and resources provide a "safety net" for these children.

Last year (Fiscal year 2002), the Families First staff processed 1,641 referrals of families whose welfare benefits had been terminated. They completed 376 home visits and made 979 home visit attempts. They were able to help these families troubleshoot problems, made many referrals for resources, and assured the health and safety of the children in the homes. There were no necessary reports of abuse or neglect to the Department of Children's Services.

## Success by 6

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# The Healthy Child

Phil Thomas, Outreach Worker, EPSD&T Team

The EPSD&T team recently joined the Maternal Child Health Division of the Metropolitan Public Health Department (MPHD). What is the meaning of the acronym, you might ask, and the answer is Early Periodic, Screening, Diagnosis, and Treatment. The MPHD has been charged with complying with a Federal mandate to ensure that the Medicaid-eligible pediatric population receives regular screening, vision, hearing, dental, and treatment services consistent with established standards. Another purpose of EPSD&T is to ensure preventive health care and follow-up treatment. Approximately 466,000 individuals are in plans for which Tennessee has full or shared risk, and approximately 190,000 are in plans that are at full risk.

To reach this targeted population, the EPSD&T team has created an outreach mode of operation to educate and encourage participation by placing emphasis on the need to be pro-active versus reactive in essential medical needs. The team utilizes any avenues available such as canvassing the neighborhood community centers, the daycares, and the homeless shelters, to speaking with individuals in the clinics especially those on the WIC (Women, Infants, and Children) program.

Working closely with the Success by Six staff, the EPSD&T team is able to go directly on many sites to conduct the screenings. This positive partnership also provides additional assessments for the youth. In making our services readily available and convenient, we are striving to make our program quite user friendly.

When you are able to look into the smiling or at times tearful eyes of a child, you may find it rather rewarding to know that you have assisted the child hopefully with starting a new healthy regiment. Seeing the relief in their parents' eyes when they are re-engaged with their primary care providers and realize that the medical needs of their child can be taken care of emphasizes the fact that EPSD&T program is truly caring for children!

If you see the Success by Six mobile unit parked in the community, the EPSD&T team may also be there. Feel free to stop by and say hello to Thoris, Kathryn, Wendy, Paula, Theresa, and Phil.

For more information about the EPSD&T program, contact the team at 615-880-2180.

***...the EPSD&T team has created an outreach mode of operation to educate and encourage participation by placing emphasis on the need to be pro-active versus reactive in essential medical needs.***

## Early Periodic Screening Diagnosis and Treatment Quick Facts

- 42% of the children in Tennessee are enrolled in TennCare and are therefore eligible for EPSDT screenings
- Between a third and a half of Tennessee children are enrolled in TennCare
- Between July 2001 and February 2002, 22,000 EPSDT screenings were done in the state
- Between August 2001 and February 2002, over 60,000 dental screenings were done statewide
- In 2001, 88.2% of 24 month old children were age appropriately immunized. There is only a 4.1% difference in the immunization rates of the TennCare and non-TennCare populations--86.3% versus 90.4%.

Taken from the Progress on Child Health: 10 Months Later Report. EPSDT Update. Children's Health Initiative. April 12, 2002.

# Perinatal Periods of Risk

Kimberlee Wyche-Etheridge, MD, MPH, Director Maternal Child Health

Started nearly 20 years ago at the Centers for Disease Control and Prevention initiative, Perinatal Periods of Risk (PPOR) has been working to change the approach to infant mortality. For decades, the approach to infant mortality has concentrated on building newer and more expensive Neonatal Intensive Care Units with the highest levels of technology to save the youngest and smallest infants. However, time has shown that even with these advances, we have not been able to significantly decrease the number of infants that die before they reach their first birthday.

PPOR offers an opportunity to take a new approach, one that looks to identify gaps in the community and target resources for prevention activities. It makes infant mortality a community issue and gives more responsibility to the community to help address it.

There are several phases to the PPOR approach. Phase I identifies the populations with excess mortality. What this means is that communities of concerns are identified where infants die in numbers higher than what would be expected if they were from the community with the best health outcomes, or lowest infant mortality rates. This group with the best health outcomes is referred to as the external reference group, and consists of women who are over 20 years old, have at least 13 years of education, and are classified as being non-Hispanic white. By comparing this reference group to others, we are able to examine the 4 mortality components that contribute to infant mortality: maternal health/prematurity, maternal care, newborn care, and infant health. In addition, differences in infant mortality between racial and ethnic groups are more readily identifiable, allowing easier definition of disparities in Nashville.

Phase II of the PPOR approach concentrates on explaining the excess mortality. It looks at the possible reasons for these excess deaths by further looking at the data and also community assessments.

Nashville became one of 14 sites, or practice collaboratives, across the country to execute PPOR. These practice collaboratives have been working to “maximize the impact of PPOR as a valid, community-based tool for improving the health and well-being of women and children.”

Phase I of the process has been completed, and Phase II is grinding to a conclusion. The results from Nashville’s PPOR experience will truly revolutionize the way we have been fighting infant mortality in Davidson County. It is time to start implementing new strategies that have been tested, and proven to work, and really get down to the business of not only decreasing our local rates of infant mortality, but to also eliminate the disparities that are adding to our excess death rates.

On November 1, 2002 the Nashville PPOR Practice Collaborative will be holding a conference to present the data to key stakeholders in public health, private industry, and community organizations. The conference will be held at the Downtown Library. *For more information regarding the conference including registration, please contact the Maternal Child Health office at 615-340-5614.*

## Infant Mortality Rates\* by Race, 2000, Nashville, TN

Infant (under 1 year): 10

Neonatal (under 28 days): 5.5

White infants: 5.6

Black infants: 19.9

White neonatals: 2.3

Black neonatals: 12.3

\*Deaths per 1,000 live births

## Teen Birth Rates\* by Race and Age, 2000, Nashville, TN

All Races, Age 10 - 19: 32.7

All Races, Age 10 - 17: 16.9

White 10 - 19: 28.7

Black 10 - 19: 43.7

Other Races 10 - 19: 10.5

White 10 - 17: 12.8

Black 10 - 17: 25.6

Other Races 10 - 17: 6.0

\*Births per 1,000 women in  
age group

## Percentage of Low Birthweight Births\* by Race, 2000, Nashville, TN

All Races: 9.1

Whites: 6.8

Blacks: 14.3

Other Races: 7.4

\*Less than 5 pounds and 8  
ounces or 2,500 grams

# Division of Maternal Child Health

## Quick Reference Program Information

**Division Director:** Kimberlee Wyche-Etheridge, MD, MPH  
615-340-5614

### Central Referral System

Contact: Delphine Gentry, RN  
Intake Coordinator  
615-880-2187

The Central Referral System provides a referral system that will maximize utilization of all forms of assistance in the community for pregnant women and young children (0 – 7 years of age) and their families by simplifying the referral process and reducing duplication of efforts.

### Children's Special Services

Contact: Sheila McCloskey, RNC  
Program Director  
615-340-5697

Children's Special Services is a state-funded program for children ages birth to 21 years who have a disability and/or chronic illness. The program provides case management services and a parent support component.

### Early Periodic Screening Diagnosis and Treatment

Contact: Thoris Campbell, RN  
Coordinator  
615-880-2180

The Early Periodic Screening Diagnosis and Treatment Program encourages families with Children enrolled in TennCare to have their children screened for a well child check-up.

### Family Resource Center

Contact: Yolonda Radford, BS  
Program Director  
615-291-2091

The Northeast Nashville Family Resource Center and Clinic at Caldwell Early Childhood Center provides one stop shopping for health, social, and educational services. The Center also serves as the intake point for Families First referrals and follow-up.

### Healthy Start

Contact: Peggy Cox, MSN  
Program Director  
615-880-2159

Healthy Start is designed to support new mothers by providing education regarding child safety, child health, disease prevention, child development, and parenting skills.

### Help Us Grow

Contact: Sandra Kaylor, RN  
Program Director  
615-862-7942

The Help Us Grow Program is a case management program for high-risk pregnant women, infants, and children up to age 5 years. Public health nurses, social workers, or case managers provide services via home visits.

### School Health

Contact: Martha Snow, MSN  
Coordinator  
615-880-2138

Metropolitan Public Health Department contracts with Metro Public Schools to provide skilled nursing services in the schools.

### Success by 6 Mobile Clinic

Contact: Donna Sumners, MCD, CCC-A  
Coordinator  
615-880-2220

The Success by 6 Mobile Clinic conducts hearing, speech/language, vision, dental, and health/developmental screenings on children ages 6 months to 5 years. The mobile clinic travels to child care sites in Davidson and surrounding counties.

## Reported cases of selected notifiable diseases for July/August 2002

Disease	Cases Reported in July/August		Cumulative Cases Reported through August	
	2001	2002	2001	2002
AIDS	26	47	141	152
Campylobacteriosis	8	9	26	24
Chlamydia	327	378	1,428	1,390
DRSP (Invasive drug-resistant <i>Streptococcus pneumoniae</i> )	2	0	17	18
<i>Escherichia coli</i> 0157:H7	1	1	4	4
Giardiasis	7	3	15	24
Gonorrhea	303	248	1,159	870
Hepatitis A	11	1	26	13
Hepatitis B (acute)	5	1	17	12
Hepatitis B (perinatal)	1	2	12	17
HIV	55	49	225	207
Influenza-like Illness	0	0	131	223
<i>Neisseria meningitidis</i> disease	0	1	7	3
Salmonellosis	15	9	37	44
Shigellosis	3	0	6	7
Syphilis (primary and secondary)	22	3	64	23
Tuberculosis	17	17	44	48
VRE (Vancomycin-resistant enterococci)	7	6	44	44

### To report a notifiable disease, please contact:

Sexually transmitted diseases: John Coursey at 340-0455

Tuberculosis: Diane Schmitt at 340-5650

AIDS/HIV: Mary Angel-Beckner at 340-5330

Hepatitis C: Pat Sanders at 340-5632

Hepatitis B: Denise Stratz at 340-2174

Vaccine-preventable diseases: Mary Fowler at 340-2168

All other notifiable diseases: Pam Trotter at 340-5632

## Return Service Requested

*Public Health Watch* welcomes feedback, articles, letters, and suggestions. To communicate with *Public Health Watch* staff, please:

**Telephone:** (615) 340 - 5683

**Fax:** (615) 340 - 2110

**E-mail:** nancy\_horner@mhd.nashville.org

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